Covered California for Small Business
Change Request Form for Employees

COVERED CALIFORNIA SMALL BUSINESS

☐ Check here if changes are to be effective at renewal.

☐ **Check to Decline Coverage**
You must also read and sign the Declination Acknowledgement on Page 4.

Fax completed form to (949) 809-3264
Mail to Covered California at P.O. Box 7010, Newport Beach, CA 92658
For assistance call (855) 777-6782
or email ccsbeligibility@covered.ca.gov

EMPLOYER INFORMATION

Employer name & address

Employer phone number	Covered California for Small Business (CCSB) Group #

REASON FOR CHANGE (CHECK ALL THAT APPLY)

		EFFECTIVE DATE MM/DD/YYYY	QUALIFYING EVENT DATE MM/DD/YYYY
☐ GROUP OPEN ENROLLMENT	MUST BE RECEIVED PRIOR TO RENEWAL DATE	CHANGE WILL BE EFFECTIVE AT RENEWAL	CHANGE WILL BE EFFECTIVE AT RENEWAL
☐ NEW HIRE	INDICATE DATE COVERAGE WILL BE EFFECTIVE		
☐ PART-TIME TO FULL-TIME EMPLOYMENT CHANGE	INDICATE DATE COVERAGE WILL BE EFFECTIVE		
☐ LOSS OR GAIN OF OTHER COVERAGE	INDICATE DATE OF EFFECTIVE CHANGE AND PROVIDE LETTER FROM CARRIER OR EMPLOYER		
☐ NAME CHANGE/ADDRESS CHANGE	INDICATE EFFECTIVE DATE OF CHANGE		
☐ MARRIAGE OR DOMESTIC PARTNER ADDITION	INDICATE DATE OF MARRIAGE OR DOMESTIC PARTNER DECLARATION		
☐ BIRTH, ADOPTION, GUARDIANSHIP, FOSTER CARE OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) OF DEPENDENT CHILD	INDICATE DATE OF BIRTH, ADOPTION, GUARDIANSHIP, FOSTER CARE OR QUALIFIED MEDICAL CHILD SUPPORT ORDER		
☐ DEPENDENT TERMINATION	INDICATE EFFECTIVE DATE OF CHANGE		

PLEASE PROVIDE THE DETAIL REGARDING YOUR CHANGE(S) IN THE RESPECTIVE SECTIONS THAT FOLLOW.

EMPLOYEE INFORMATION

1. First name, Middle name, Last name & Suffix	2. Date of Birth
3. Social Security Number or Tax ID Number	Sex

NEW EMPLOYEE Complete information below. **EXISTING EMPLOYEE** Complete only information that has changed.

4. HOME address			5. Apartment or suite number
6. City	7. State	8. ZIP code	9. County
10. MAILING address			11. Apartment or suite number
12. City	13. State	14. ZIP code	15. County
16. Email address	17. Phone number ( ) ☐ Cell ☐ Home ☐ Work		18. Other phone number ( ) ☐ Cell ☐ Home ☐ Work

19. What is the preferred method of communication? ☐ Mail ☐ Email ☐ Phone

☐ **CHECK HERE IF NAME CHANGE OR CORRECTION**

20. New First Name

21. New Last Name

NEED HELP WITH YOUR FORM? Contact your employer or your employer's Covered California Certified Insurance Agent with questions, visit **coveredca.com/forsmallbusiness** or call us at (855) 777-6782. Para obtener una copia de este formulario en Español, llame (855) 777-6782.

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Employee Name	Employer Name	CCSB Group

COMPLETE THIS SECTION TO CANCEL COVERAGE, ADD DEPENDENTS OR CHANGE PLANS

IMPORTANT! Plan changes are allowed during renewal and for employees who experience a qualifying event (i.e. newborn).

- **CANCELLATIONS** of coverage will take effect on the **LAST DAY** of the month **AFTER RECEIPT** of your request by Covered California. Cancellations at renewal will take effect on the group's renewal date.
- **ADDITIONS (QUALIFYING EVENT):** Please see your employer for effective date guidelines based on qualifying event.
- **ADDITIONS (AT RENEWAL):** Coverage will be effective on the group's renewal date.
- **CHANGES (AT RENEWAL):** If making any plan changes, please list all covered dependents.

This form must be received by Covered California **NO LATER THAN 30 DAYS** after the event takes place if outside renewal.

EMPLOYEE

LAST NAME (FAMILY NAME) | FIRST NAME | MI | SSN/ TAX ID # | SEX

BIRTHDATE MM/DD/YYYY | NAME OF HEALTH PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL | NAME OF DENTAL PLAN SELECTED (OPTIONAL)

Please see the following page for the available CCSB health and dental plans to choose from.

REASON | LAST DAY OF COVERAGE

SPOUSE OR DOMESTIC PARTNER

LAST NAME (FAMILY NAME) | FIRST NAME | MI | SSN/ TAX ID # | SEX

BIRTHDATE MM/DD/YYYY | ARE YOU A DOMESTIC PARTNER? ☐ YES ☐ NO | IF YES, IS THE PARTNERSHIP REGISTERED WITH THE STATE OF CALIFORNIA? ☐ YES ☐ NO | DENTAL PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL | REASON | LAST DAY OF COVERAGE

CHILD

LAST NAME (FAMILY NAME) | FIRST NAME | MI | SSN/ TAX ID # | SEX

BIRTHDATE MM/DD/YYYY | IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER? ☐ YES ☐ NO | DENTAL PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL | REASON | LAST DAY OF COVERAGE

ADDRESS IF DIFFERENT THAN EMPLOYEE | STREET | CITY | STATE | ZIP

CHILD

LAST NAME (FAMILY NAME) | FIRST NAME | MI | SSN/ TAX ID # | SEX

BIRTHDATE MM/DD/YYYY | IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER? ☐ YES ☐ NO | DENTAL PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL | REASON | LAST DAY OF COVERAGE

ADDRESS IF DIFFERENT THAN EMPLOYEE | STREET | CITY | STATE | ZIP

CHILD

LAST NAME (FAMILY NAME) | FIRST NAME | MI | SSN/ TAX ID # | SEX

BIRTHDATE MM/DD/YYYY | IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER? ☐ YES ☐ NO | DENTAL PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL | REASON | LAST DAY OF COVERAGE

ADDRESS IF DIFFERENT THAN EMPLOYEE | STREET | CITY | STATE | ZIP

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Employee Name	Employer Name	CCSB Group

NEW HEALTH AND DENTAL PLAN CHOICES

IMPORTANT! Plan changes are only allowed at renewal. However, employees who experience a qualifying event (e.g. acquire a new dependent) are able to change their coverage outside of the renewal period.

NOTE: Infertility benefits are available to employer groups when an employer elects to provide this benefit during open enrollment or renewal periods. If an employer with 20 or more eligible employees elects to provide infertility benefits, all plans offered will include the this coverage.

If an employer with less than 20 eligible employees elects to provide infertility benefits, only PPO plans will include this coverage. Infertility benefits will not be included in HMO plans for groups with less than 20 eligible employees.

Plan selection varies by region. Please check with your employer for the list of available health plans in your area.

Health Plan	METAL TIER			
	Bronze	**Silver**	**Gold**	**Platinum**
Blue Shield of California	◯ Bronze 60 PPO 6300/60 + Child Dental ◯ Trio Bronze 60 HMO 7000/70 + Child Dental Alt ◯ Bronze 60 HDHP PPO 7500/0% + Child Dental Alt	◯ Silver 70 PPO 2500/55 + Child Dental ◯ Trio Silver 70 HMO 2500/55 + Child Dental ◯ Silver 70 HDHP PPO 2300/30% + Child Dental Alt ◯ Access+ Silver 70 HMO 2500/55 + Child Dental	◯ Gold 80 PPO 350/25 + Child Dental ◯ Trio Gold 80 HMO 250/35 + Child Dental ◯ Access+ Gold 80 HMO 250/35 + Child Dental	◯ Platinum 90 PPO 0/15 + Child Dental ◯ Trio Platinum 90 HMO 0/20 + Child Dental ◯ Access+ Platinum 90 HMO 0/20 + Child Dental
Kaiser Permanente	◯ Bronze 60 HMO 6300/60 + Child Dental ◯ Bronze 60 HMO 5400/60 + Child Dental Alt ◯ Bronze 60 HDHP HMO 7050/0% + Child Dental	◯ Silver 70 HMO 2500/55 + Child Dental ◯ Silver 70 HDHP HMO 2850/25% + Child Dental ◯ Silver 70 HMO 1900/65 + Child Dental Alt ◯ Silver 70 HMO 2300/65 + Child Dental Alt ◯ Silver 70 HMO 2950/65 + Child Dental Alt	◯ Gold 80 HMO 250/35 + Child Dental ◯ Gold 80 HMO 1000/40 + Child Dental Alt ◯ Gold 80 HMO 0/35 + Child Dental Alt ◯ Gold 80 HDHP HMO 1750/15% + Child Dental Alt	◯ Platinum 90 HMO 0/10 + Child Dental Alt ◯ Platinum 90 HMO 0/20 + Child Dental ◯ Platinum 90 HMO 250/30 + Child Dental Alt
Sharp	◯ Performance Bronze 60 HMO 6300/60 + Child Dental ◯ Premier Bronze 60 HDHP HMO 7050/0% + Child Dental	◯ Premier Silver 70 HMO 2500/55 + Child Dental ◯ Performance Silver 70 HMO 2500/55 + Child Dental ◯ Premier Silver 70 HDHP HMO 2850/25% + Child Dental	◯ Performance Gold 80 HMO 350/25 + Child Dental ◯ Premier Gold 80 HMO 250/35 + Child Dental	◯ Performance Platinum 90 HMO 0/15 + Child Dental ◯ Premier Platinum 90 HMO 0/20 + Child Dental

*****For health plans that do not include Child Dental, employees have the option to elect a standalone pediatric dental plan. Dependent children are eligible for Pediatric Dental coverage up to age 19.

Dental Plans	PEDIATRIC DENTAL PLANS	FAMILY DENTAL PLANS**
Delta Dental	◯ Children's Dental HMO ◯ Children's Dental PPO	◯ Family Dental HMO ◯ Family Dental PPO
Dental Health Services		◯ Family Dental HMO

****** Family dental plans offer both adult only and adult plus child coverage.

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SIGN THE FORM

COVERED CALIFORNIA BINDING ARBITRATION AGREEMENT

I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the Health Plan, including , for premises liability, relating to the coverage for, or delivery of, services or items, or, if I select a Kaiser Permanente Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the Health Plan's coverage document, which is available for my review.

I am signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Signature of Employee	Date (mm/dd/yyyy)
Employer Name	

STOP! ONLY complete and sign below if you are declining coverage.

DECLINATION ACKNOWLEDGEMENT

I am declining medical coverage for (check all that apply):

- ☐ Self
- ☐ Spouse / Domestic Partner
- ☐ Child(ren) Name(s) _____

I am declining **dental coverage** for (check all that apply):

- ☐ Self
- ☐ Spouse / Domestic Partner
- ☐ Child(ren) Name(s) _____

Reason for declining coverage (choose one):

- ◯ Covered by spouse's / domestic partner's group plan
- ◯ Covered by individual policy
- ◯ Covered by Tricare
- ◯ Covered by Medicare
- ◯ Covered by Medi-Cal
- ◯ Covered by Other:
- ◯ Coverage is too expensive. *(You may want to contact Covered CA at www.coveredca.com for help in understanding the available options and financial assistance in the Covered Ca Individual Marketplace)*

☐ **I acknowledge that the coverage available to me has been explained to me by my employer and I have the right to enroll in the coverage offered. I have voluntarily decided not to enroll myself and/or my eligible dependent(s). By declining this coverage I acknowledge that I and/or my eligible dependents will have to wait until my employer's next open enrollment period to enroll or change coverage, unless eligible for a special enrollment period through a qualifying event.**

Signature of Employee	Date (mm/dd/yyyy)
Employer Name	

CERTIFIED INSURANCE AGENT INFORMATION

Please tell us the Certified Insurance Agent who assisted you with your Covered California for Small Business health coverage.

Certified Insurance Agent Name	Email	Phone Number

☐ **I did not receive assistance from a Certified Insurance Agent.**

RETURN YOUR COMPLETED, SIGNED FORM TO YOUR EMPLOYER

Your employer will send us your form, and we will contact you if we need additional information or to let you know your request for changes to your coverage have been approved.

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